Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgement before publication.

Hepatocellular Carcinoma—Screening and Latency Period

TO THE EDITOR: I was surprised that the recent Medical Staff Conference on primary hepatocellular carcinoma[1] did not include a discussion of screening among high-risk populations. It has been known for a number of years that at a very early, resectable stage, hepatocellular carcinoma releases measurable and abnormal amounts of α-fetoprotein. A screening program based on this fact led to the early diagnosis of 134 cases of primary hepatocellular carcinoma in Shanghai in the early 1970s.[2] In our country, an active screening program among Alaskan natives by the Alaska Native Health Service in conjunction with the Centers for Disease Control has led to the early diagnosis of resectable malignancies in more than one person.[3] While the Medical Staff Conference discussed treatment of advanced carcinoma in some detail, it completely ignored such proved screening efforts, which might hold out a great deal of hope for populations in other parts of the world where the disease is endemic.

I also question the statement that the latency period is 40 years from the onset of hepatitis B carriage to the development of carcinoma. Many cases have occurred in young patients who clearly have been carriers for only a few years at most.

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REFERENCES

1. Tseng A: Primary hepatocellular carcinoma—Recent advances and future prospects—Medical Staff Conference, University of California, San Francisco. West J Med 1985 Oct; 143:503-507

2. Shanghai Coordinating Group for Research on Liver Cancer: Diagnosis and treatment of primary hepatocellular carcinoma in early stages: Chin Med J 1979; 92:801

3. Heyward WL, Lanier AP, Bender TR, et al: Early detection of primary hepatocellular carcinoma by screening for alpha-fetoprotein in high risk families. Lancet 1983; 2:1161-1162

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Dr Tseng Replies

TO THE EDITOR: The screening of high-risk populations for hepatocellular carcinoma (HCC) does indeed offer the potential of discovering an early, resectable lesion. Dr Trotter is correct in stating that screening programs might provide hope for populations in other parts of the world where HCC is endemic. Kubo and co-workers[1] state that a continuous check of serum α-fetoprotein levels in patients with chronic liver disease is imperative in areas where HCC is frequent. However, α-fetoprotein screening, although convenient, may not be sensitive enough in detecting early HCC.[2] Ultrasonography of the liver, combined with α-fetoprotein screening, may provide a more sensitive and feasible alternative.[3] Whether such screening programs in countries where HCC is common will be cost effective and impact on long-term patient survival remains to be determined.

The association of HCC and prior exposure to hepatitis B virus is intriguing. Beasley and associates reported 116 cases of HCC in 22,707 Taiwanese men, with 113 cases among 3,454 carriers of the hepatitis B surface antigen.[4] In this study, the greatest incidence per 100,000 population occurred in patients between 50 and 70 years of age. The incidence of HCC rose with increasing age, so the risk appeared to be a function of the duration of the HBsAg carrier state. Although a prolonged latency period of 20 to 30 years has also been reported by Arthur and colleagues[5] for adult HCC, hepatitis B virus may also play a role in the development of HCC in children.[6,7] Such cases are rare and the incidence of HBsAg positive cases is much lower than in adults;[8] however, in high-risk populations, the disease does occur in younger age groups.

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REFERENCES

1. Kubo Y, Okuda K, Musha H, et al: Detection of hepatocellular carcinoma during a clinical follow-up of chronic liver disease: Observations in 31 patients. Gastroenterology 1978; 74:578-582

2. Tang ZY, Ying YY, Gu TF: Hepatocellular carcinoma: Changing concepts in recent years. *In* Popper H, Schaffner F (Eds): Progress in Liver Disease. Vol III. Philadelphia, Grune and Stratton, 1982, pp 637-647

3. Chen DS, Shen JG, Sung JL, et al: Small hepatocellular carcinoma—A New York clinicopathological study in thirteen patients. Gastroenterology 1982; 83:1109-1119

4. Beasley RP, Hwang LY, Lincc, et al: Hepatocellular carcinoma and HBV: A prospective study of 22,707 men in Taiwan. Lancet 1981; 2:1129-1133

5. Arthur MJP, Hall AJ, Wright R: Hepatitis B, hepatocellular carcinoma, and strategies for prevention. Lancet 1984; 1:607-610

6. Weinberg AG, Finegold JF: Primary hepatic tumors of childhood. Hum Pathol 1983; 6:512-537

7. Beasley RP, Shiao IS, Wu TC, et al: Hepatoma in an HBsAg carrier—Seven years after perinatal infection. J Pediatr 1982; 101:83-84

8. Ohaki Y, Misugi K, Sasaki Y, et al: Hepatitis B surface antigen positive hepatocellular carcinoma in children—Report of a case and review of the literature. Cancer 1983; 51:822-828

AIDS—The Responsibility of Health Workers to Assume Some Degree of Personal Risk

TO THE EDITOR: Despite the plethora of published writings on medical ethical subjects that have appeared in recent years, little or no attention has been directed to the obligation or duty

of those who profess to be health workers to assume some degree of personal risk in the course of their work with patients.

An extensive search of the literature failed to find any discussion of this subject except for a passing mention in a recent article on acquired immunodeficiency syndrome (AIDS).[1] This duty was of little import in recent years, but with the appearance of AIDS, and the accompanying hysteria, it has been called into question. Some physicians and some nursing personnel are refusing to care for AIDS patients because of an exaggerated fear of the disease and its transmissibility. Some patients are refusing to be treated by professionals who also treat AIDS patients, or to be cared for in institutions which admit AIDS patients. The AIDS patient has become the leper of the 20th century.

If a citizen is standing by the seashore and sees someone drowning off the coast and dives in and saves the person, he or she is a hero. If, however, the citizen is a poor swimmer and fears drowning, he or she is under no moral obligation to try to make the rescue. On the other hand, if that citizen professes to be a lifeguard, he or she has an obligation or duty to make the attempt, no matter how dangerous. Similarly, if a person needs rescue from a burning building, a passerby is not obligated to risk his or her life to make the rescue. Yet a fireman is duty bound to try. There is, it seems to me, a similar compelling obligation for health care professionals to assume some risk, if it is required, in order to care for the sick and the injured.

This is not a new concept, although little has been written about it lately. In the Middle Ages, during the black plague, physicians and nurses did their duty and some were among the casualties. During the yellow fever and typhoid epidemics of the late 1800s and early 1900s, health professionals took their risks and cared for the sick. Doctors and nurses cared for victims of leprosy, tuberculosis and poliomyelitis before their means of transmission, preventive measures or cures were known. More recently, health care professionals have cared for victims of hepatitis at considerable risk to themselves. Can it be that the duty and obligation to care for victims of AIDS is any less?

The question may be raised as to how much risk it is the duty of health professionals to assume. This is a difficult, if not impossible, question to answer on a theoretical or philosophical level. In the case of AIDS, however, the statistical risk of acquiring the disease from caring for a patient is extraordinarily small.[1,2] The disturbing feature is that if AIDS is contracted, the outcome is fatal in our present state of knowledge. Fortunately, we have excellent data to demonstrate that, with ordinary sanitary precautions, the risk of exposure to the virus and seroconversion to positive for HTLV-III virus is about 2 in 1,000, even if we accidentally puncture ourselves with a contaminated needle from an AIDS patient. So far, no case of AIDS is known to have been transmitted by surface contamination with blood or excreta from an AIDS patient, even with repeated close contact in a family (nonsexual) situation.[3]

In summary, the risk to health care professionals of contracting AIDS in the course of their caring for patients is exceedingly small. The risk to non-AIDS patients of being infected by health personnel who also care for AIDS patients is essentially nil. It is true that to be infected with AIDS virus is serious and to develop the disease is fatal. Even if one is infected with the virus, however, the risk of the disease developing appears to be about 1 in 10. Nevertheless, in the face of this risk, it is still the duty and obligation of those professing to be health workers (especially physicians and nurses) to care for patients with AIDS as they would for any other patients.

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REFERENCES

1. Volberding P, Abrams D: Clinical care and research in AIDS. Hastings Cent Rep, 1985 Aug (Special Report)

2. Centers for Disease Control: Update evaluation of human T-lymphotrophic virus type III—Lymphadenopathy-associated virus infection in health care personnel—United States (Epidemiologic Notes and Reports). MMWR 1985 Sep 27; 34:575-578

3. Krim M: AIDS: The challenge to science and medicine. Hastings Cent Rep 1985 Aug; (Suppl):2-7

Entamoeba histolytica Spread by Food

TO THE EDITOR: In the January 1986 issue, Dr David Dassey comments, "there is no report in the literature known to me of *Entamoeba histolytica* being spread by contaminated food."[1] A classical proof for such spread appeared in 1936 in a detailed article by George W. McCoy that reported the 1933-1934 Chicago epidemic.[2]

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REFERENCES

1. Dassey DE: Correction—Hepatitis A (Correspondence). West J Med 1986 Jan; 144:92

2. McCoy GW, et al: Epidemic amoebic dysentery. Natl Inst Health Bull 1936; 166